

2009 Medical Options Comparison

State of Tennessee Group Insurance Program

State and Local Education Plan Participants

	PPO OPTION		POS OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Preexisting Condition Requirement	6 months if no immediately prior coverage		6 months if no immediately prior coverage		None
Annual Medical Deductible *	\$350 per individual; \$875 family *		None	\$300 per individual; \$750 family	None
Annual Medical Out-of-Pocket Maximum (excludes MH/SA and pharmacy)	\$1,350 per individual; \$2,700 family	\$4,050 per individual; \$8,100 family	None		None
Annual Physical Exam — Adult	90% of MAC	70% of MAC	100% benefit (office visit copay may apply)	70% of MAC after deductible	100% benefit (office visit copay may apply)
Physician Office Visit	90% of MAC	70% of MAC	\$25 copay general; \$30 copay specialist	70% of MAC after deductible	\$20 copay PCP; \$25 copay specialist
Maternity	90% of MAC	70% of MAC	\$25 copay general; \$30 copay specialist, first visit only; \$100 copay hospital admission	\$300 copay, then 70% per diem after deductible	\$20 copay PCP; \$25 copay specialist, first visit only; \$100 copay hospital admission
Well Child Checkup and Immunizations	90% of MAC; 12 visits covered through age 5, annually for ages 6-17	70% of MAC; 12 visits covered through age 5, annually for ages 6-17	100% benefit (office visit copay may apply); 12 visits covered through age 5, annually for ages 6-17	70% of MAC after deductible; 12 visits covered through age 5, annually for ages 6-17	100% benefit (office visit copay may apply); 12 visits covered through age 5, annually for ages 6-17
Lab and X-ray	90% of MAC	70% of MAC	100% benefit	70% of MAC after deductible	100% benefit
Physical, Speech and Occupational Therapy	90% of MAC; Some limitations may apply	70% of MAC; Some limitations may apply	\$20 copay per visit; Limited to 45 visits per year, per condition	70% of MAC; Limited to 45 visits per year, per condition after deductible	\$15 copay per visit; Limited to 45 visits per year, per condition
Chiropractic Care	90% of MAC; Maintenance visits not covered when no additional progress is apparent or expected to occur	70% of MAC; Maintenance visits not covered when no additional progress is apparent or expected to occur	\$25 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur	70% of MAC after deductible; Maintenance visits not covered when no additional progress is apparent or expected to occur	\$20 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur
Ambulance Service — Air and Ground	80% of reasonable charges when deemed medically necessary by claims administrator		100% of reasonable charges when deemed medically necessary by claims administrator		100% of reasonable charges when deemed medically necessary by claims administrator
Emergency Room	\$75 copay per visit (waived if certain conditions are met); 90% of MAC	\$75 copay per visit (waived if certain conditions are met); 70% of MAC	\$75 copay per visit (waived if certain conditions are met)	\$75 copay per visit, then 70% of MAC after deductible (copay waived if certain conditions are met)	\$75 copay per visit (waived if certain conditions are met)
Hospital Care	90% of MAC	70% of MAC	\$100 per admission	\$300 per admission, then 70% per diem after deductible	\$100 per admission
Prescription Drug Coinsurance/Copay **	\$5 generic; \$25 preferred brand; \$75 non-preferred brand ** Extended prescription up to 102 days \$10/\$50/\$100	\$5 generic; \$25 preferred brand; \$75 non-preferred brand + amount exceeding MAC ** Extended prescription up to 102 days \$10/\$50/\$100	\$5 generic; \$25 preferred brand; \$75 non-preferred brand ** Extended prescription up to 102 days \$10/\$50/\$100	70% of MAC after deductible	\$5 generic; \$25 preferred brand; \$75 non-preferred brand ** Extended prescription up to 102 days \$10/\$50/\$100
Annual Pharmacy Copay Maximum	\$1,620 per individual **		None		None
Mental Health Inpatient * (preauthorization required)	90% of MAC; Limited to 45 days per year	70% of MAC; Limited to 45 days per year	\$100 copay per admission; Limited to 30 days per year	Not covered	\$100 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient * (preauthorization required)	90% of MAC; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	70% of MAC; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	\$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	Not covered	\$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health/Substance Abuse Outpatient * (preauthorization required)	Sessions 1-15: \$5 copay per session Sessions 16-45: \$25 copay per session Limited to 45 sessions per year mental health and substance abuse combined	Sessions 1-15: \$40 copay per session Sessions 16-45: \$100 copay per session Limited to 45 sessions per year mental health and substance abuse combined	\$25 copay per session; Limited to 45 sessions per year mental health and substance abuse combined	Not covered	\$20 copay per session; Limited to 45 sessions per year mental health and substance abuse combined

The benefits listed are a summary of some common benefit categories. Please refer to vendor member handbooks for complete information on coverage, limitations and exclusions.
MAC — Maximum Allowable Charge. Use of out-of-network providers will result in increased cost to members as you will be required to pay the difference between the MAC and the amount billed by the provider.
* Separate \$150 deductible for mental health/substance abuse care required under the PPO; Benefits must be preauthorized by Magellan Health Services to be reimbursable at the highest level for the PPO. If preauthorization is not obtained, benefits will be reduced for the PPO and denied for the POS and HMO.
** Does not apply to annual medical deductible or the annual medical out-of-pocket, if applicable. If cost of prescription is less than the copay, the lesser amount will apply. Copay for oral diabetic medications and insulin waived for generic and preferred brand when using in-network pharmacy.